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ABSTRACT

This report describes the outcomes of a Wyoming program that provides host families for individuals with developmental disabilities. Host families work with certified Medicaid providers of home and community-based services for people with developmental disabilities and provide residential habilitation to an adult who is accepted as a member of their family. The first part of the report discusses findings from a study involving 13 adults with mental retardation who were in host families for 9 to 11 months. Results from the study indicate there was a positive change in the individuals when they lived with host families compared to the same individuals while they lived in an institution or at the beginning of their placement with a regional service provider. Incident reports of inappropriate behavior decreased significantly in eight individuals who had had maladaptive behaviors. All 13 individuals maintained or improved their health status, including 3 individuals who lost an average of 42 pounds. Two individuals have been able to slightly decrease psychotropic medications since their move to a host family. The second part of the report presents case studies of four participants who have lived in a host family and have made exceptional gains. (Contains 16 references.) (CR)

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Home on the Range: Host Families for Developmental Disabilities in Wyoming

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June, 2000

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Abstract

Several people have asked me to explain to them what a host family is. The best explanation I can give you is to describe a surprise visit to an established host family. My visit began at 6:45 a.m. with Gerald answering the door. He smiled and invited me in. Joe was wearing his plaid nightshirt eating cereal at the kitchen table. Florence emerged from the bedroom dressed and ready for the day. Behind her was Melanie, still wearing a robe but smiling and wondering what I was doing there so early. As their morning routine began, Joe asked if I would like a glass of juice to drink. Florence got her cereal from the counter and milk from the refrigerator. Gerald and Melanie were getting medications from the cupboard while Joe set out the blood sugar level monitor. After reading this narrative, can you identify the client (s) from the paid provider (s)? My guess is you cannot, and that is the true essence of a host family – being a family. The Host family provider is basically an extended family for a person with a developmental disability. Tax-free monthly income helps support the home with the individual served paying for room and board. This residential model offers a lot of belonging and satisfaction by the people living together, good learning chances, and community integration. This is an alternative to the group home, a shared residence that may miss some of the feelings of belonging and family unity that the host family model often seems to provide.

Home on the Range: Host Families for Developmental Disabilities in Wyoming

Wyoming has long been known for it's wide-open spaces, wildlife, and scenic beauty. The state's reputation for rugged individualism has influenced the authors and artists of history books and fictional novels. Wyoming has been characterized by some as "profoundly" rural; here towns are few and far between. Frequently, one hundred miles or more of wind swept plains or snow covered mountains, separate towns that lend themselves to the mystery and intrigue of this unique state.

The remoteness and desolation of Wyoming's 97,812 square miles creates in some people's mind an image of disconnectedness. In actuality, the 482,000 Wyoming inhabitants find in each other a commonality, which eliminates spatial distance and ties together, the bonds of humanity. This commonality is reflected in the munificentness of the host families in the northwest corner of Wyoming, known as the Big Horn Basin. New to the State of Wyoming, host families have reached into the depths of love and compassion by opening their homes and lives to people with developmental disabilities. Host families work with certified Medicaid providers of home and community-based services for people with developmental disabilities. They provide residential habilitation to an adult who is accepted as a member of their family.

Many individuals with developmental disabilities are realizing the goal of full participation in community life. The gains in adaptive behavior for those who

have moved into the community are greater than those shown by institutional counterparts (Rose, White, Conroy, & Smith, 1993). Nationally, there have been some definite changes in beliefs, provision of services, and policies regarding the treatment of people with developmental disabilities. These changes are reflected in the custom in which people are addressed (Greenwood, 1987). In the past, it was the rule to refer to the group as handicapped people. Now the emphasis is placed on the person rather than the disability.

This change of belief is no more evident than in the host family program. The host family considers the person living in their home a family member, not a client or consumer. This residential model offers a plethora of opportunities to individuals who might not otherwise have the opportunity to experience while living in a group home or institution. These opportunities include a wide scope of community integration, a high degree of learning chances, the sense of belonging and the satisfaction of people living together. Individuals no longer undergo the regiment of group home living where different shifts interrupt the typical daily living arrangements or staff members change as frequently as people may change their socks.

Host family services are provided under a contract with Big Horn Enterprises to provide a home for developmentally disabled adults (18 years and older) with a non-family member. Tax-free monthly income helps support the home with the individual paying for room and board.

The following pages will demonstrate the power that host family programs can have in bringing out the positive potential in people with developmental

disabilities and in positively altering stereotypes and expectancies of service providers and communities. The first part of this paper will illustrate if testing scores correspond with the seemingly dramatic behavioral and social changes in the lives of the thirteen individuals. In the second part of this paper, four case studies will describe the successful experiences of individuals with histories of self-injurious and aggressive behaviors that moved from the Wyoming State Training School to group home settings; then to a host family. The case studies will demonstrate how a family setting lifestyle can reduce maladaptive behaviors and increase adaptive behaviors. In the short time Big Horn Enterprises, Inc., has incorporated the host family program there have been exciting physical and emotional behavior changes.

Between 1988 and 1994, Wyoming began to reduce its census at the state's only institution, the Training School, from 389 to 154 individuals (Fortune, Heinlein & Fortune, 1995). Most of the reduction occurred because of the requirements resulting from a lawsuit (Weston, et al. v. WSTS, et al., C90-0004) in 1990, and was funded through the state's adult and child home and community based Medicaid waivers. The waivers increased money available to purchase services and increased the amount of services available (Heinlein & Fortune, 1995). Nine of the thirteen individuals in host families moved from the Training School during the time period of 1988 to 1998. One individual aged out of the Wyoming Department of Family Services system and three came from their family homes that could no longer adequately care for the individuals. All thirteen individuals have adult Medicaid home and community based waiver funding.

The thirteen adults have full scale IQs that range from under 30 to 66 corresponding to mental retardation levels of profound to mild. Service levels range from extensive personal care, the lowest score recorded at level 2; to limited personal care, the highest level at a score of 7. This indicates an extensive continuum of disabilities. Primary diagnosis (in addition to mental retardation) includes Down Syndrome, Intermittent Explosive Disorder, Autism, Bipolar Disorder and Post-Traumatic Stress Disorder (Chronic). Secondary diagnosis includes seizures, limited speech articulation, hearing impairment, retinitis pigmentation, neurofibromatosis, physical health problems, and situational mental health problems. The age of the thirteen adults ranges from 23 to 65 years.

Method

In 1988, community program personnel and Wyoming State Training School staff members, were trained in the use of the Inventory for Client and Agency Planning (ICAP), and administered the instrument to all persons being served. The ICAP CompuServe software was used to generate the reported results and the ICAP utilities software program version 1.1 was used by Wyoming's Division of Developmental Disabilities to compile various statewide results (Heinlein & Fortune 1995). Since 1988, the Training School and statewide service providers have used the ICAP to monitor and track individual progress or regression.

Using a longitudinal panel study, Big Horn Enterprises, will show the measures of the thirteen individuals in a host family for 1996, and 2000. This allows comparison of the ICAP scores and documents all thirteen individuals. In

1996 the ICAP scores are reported after the thirteen people were placed with Big Horn Enterprises, a community service provider for three or more years. By the year 2000 the results are noted after the individuals experienced nine to eleven months of living with a host family.

Instrument

The Inventory for Client and Agency Planning (ICAP) (Bruininks, Hill, Weatherman, and Woodcock, 1986) is a comprehensive, 123-item standardized instrument to assess the adaptive functioning, problem behavior, functional characteristics and service needs of individuals with developmental disabilities. Leal (1992) identifies that the ICAP authors had extensive, appropriate backgrounds and experiences, and that the instrument is statically related to the Scales of Independent Behavior (SIB) and the Woodcock-Johnson Psycho-Educational Battery. The ICAP measures adaptive behavior in four fields – social and communication, personal living, community living and motor skills. The problem behavior measures maladaptive behavior in three areas: internalized, externalized, and asocial. The ICAP score ranges from 0 to –74 with a standard deviation of –10. For example, no maladaptive problems could be recorded with a zero and serious maladaptive behavior problems would be reported with increasingly larger negative numbers such as –40.

The ICAP service score ranges form 0 to 100. The ICAP service level ranges from 1 to 9. The ICAP service score is the weighted average of the adaptive (.7) and maladaptive (.3) scores. Persons receiving an ICAP level 1 service score require total care and intensive supervision and a level 9 represents total

independence. Levels 4 through 6 identify supervised intermediate care and levels 7 through 9 represent that limited care is required. The ICAP was developed recognizing that adaptive and problem behaviors interact and that neither score is sufficient to predict the level of service required. The service needs section of the ICAP combines adaptive behavior and problem behavior scores to yield an overall measure (called the service score) of the individuals' need for care, support, supervision, and training. The test-retest and inter-rater reliabilities are in the .8 to .9 range (Bruininks, Woodcock, Hill & Weatherman, 1986).

Informal methods were also used to collect data. These methods involved incident reports written for inappropriate behaviors, medication changes and general health nursing notes.

Results

Data indicate there was a positive of change during the four-year span of administering the ICAP for the thirteen individuals placed in host families. Table 1. illustrates the mean of ICAP scores during 1996, and 2000. All three ICAP results, the service scores, maladaptive score, and adaptive score show an improvement. The mean service scores in the year 2000 is 11 points higher. Both adaptive and maladaptive results for the group are also better. The increase of a entire ICAP service level would indicate the positive effect host families have on a person with developmental disabilities compared to the same individuals while they lived in an institution or at the beginning of their placement with a regional service provider.

Table 1.

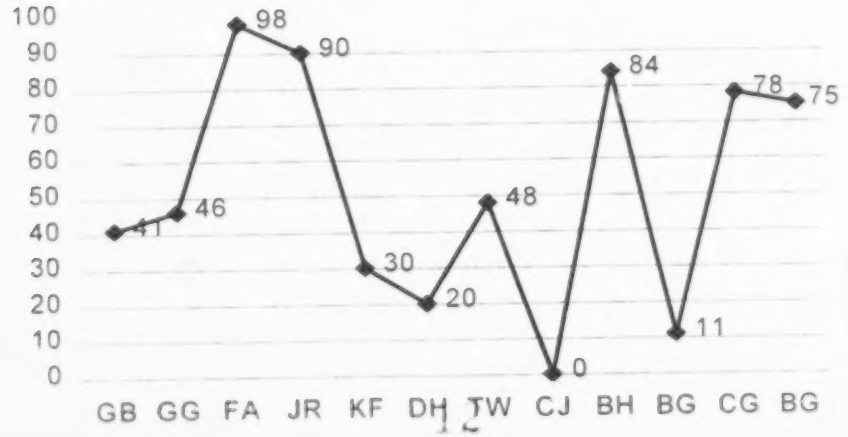
A Comparison of the ICAP results of 13 Adults in host family in 1996 and 2000

ICAP Measure	1996	2000
Service Score	44.5	54.6
Maladaptive Score	-19.5	-13.5
Adaptive Score	447.5	458.5

A paired t analysis also suggests that the four year service score point gain 11.46 for the 13 people is significant. A paired t test comparison resulted in t (12) = -3.037, $p < .010$.

Also informal methods of collecting data indicate a positive trend of improvement for all thirteen individuals. Incident reports of inappropriate behavior decreased significantly in eight individuals. Incident report data was

Table 4.
Percent of Decrease in Behavioral Incident Reports



collected analysis from January 1998 to February 2000. Four individuals did not exhibit or had few maladaptive behaviors before host family placement and showed no change in behaviors after the move. One individual who moved from his apartment to a host family for health and safety reasons experienced a thirty-six percent increase in behaviors. Table 4 illustrates the percent of decreased individual behavior change in 12 of the 13 people. The average person has almost one half (48%) of the former number of incident reports.

Medically, all thirteen individuals have maintained or improved their health status. Outstanding notations include three individuals losing an average of 42 pounds, moving them into the normal range of weight for their age group. One individual was able to gain control of his diabetes enabling him to decrease his diabetic medication. This same person, after years of smoking, quit with the encouragement of his host family. Another individual has not been administered Ativan for aggression since the first month of her move to a host family. Prior to the move this individual was required to undergo a thirty-day evaluation from a psychiatrist for her aggressive and destructive behavior. Two individuals have been able to slightly decrease psychotropic medications since their move to a host family.

The host family program has had a positive effect on all thirteen individuals. According to ICAP scores, maladaptive behaviors have decreased, while adaptive skills have increased for each person. Individuals receive more formal and incidental training in the home environment and in the community.

Case Study Overview

Four of the thirteen people who moved into a host family have made exceptional gains. The following case studies will explain the areas of their growth and improvement from the group home to a host family setting.

Tammy, Case Study #1

Tammy is a thirty-seven year old female of average size and build. She wears glasses and hearing aids. Her primary disability is moderate mental retardation with a dual diagnosis of autism (DSM IV, 318.00 and 299.00). She is very compulsive and has little patience when she wants something. Daily routine and structure is important to her well being.

Prior to Tammy's birth, her mother was admitted to a home for unwed mothers. Because the baby (Tammy) was of mixed race, her mother and grandparents made the choice to relinquish her after the birth (social history, WSTS). Tammy was born prematurely (2 pounds, 9 ounces) at County General Hospital in Denver. She stayed in the hospital until she was two months old, at which time she was placed in a foster home in southeast Wyoming.

At the age of five the foster mother could no longer "handle" (Application for Evaluation 1968) Tammy and she was admitted to the Wyoming State Training School in Lander, Wyoming in1968. During her twenty-two year residency, she shared her bedroom with one other and lived in units occupied by up to seven others. She was employed at the institution's laundry facility, worked full time and was rated as a good employee (Norton, 1990).

Tammy moved to Big Horn Enterprises, a community based program in Thermopolis, Wyoming in 1990. During her nine year stay, she lived in two different group homes, worked as a housekeeper at the Holiday Inn, worked in the sheltered workshop doing assembly type projects, and attended day habilitation. Tammy's community activities included bowling, swimming, and going out to eat, and out of town shopping.

In May of 1999, Tammy moved into a host family setting. Her new family consists of a married couple with a 16-year-old son. Tammy has her own bedroom with room for her stereo, television and all her personal belongings. She still attends day programming and earns money by doing laundry for the janitorial crew. Tammy had the opportunity to take a vacation to Oregon and California. She did extensive site seeing to Disneyland, Knotts Berry Farm and sunbathed on the beach, something she may never have had the chance to experience while living in a group home. She also is actively involved in church and community activities such as sport events, houseware parties, and movies.

Throughout Tammy's life, she has a history of engaging in three types of problematic behavior. The first is self-abuse and has, in the past, taken the form of striking her face, particularly her mouth, and banging her head on walls and floors. The second type of maladaptive behavior that Tammy exhibits has been described as obsessive-compulsive and takes a variety of forms. The most problematic is her tendency to pick up every small bit of trash in her environment and then try to flush it down the toilet. Finally, Tammy exhibits some behaviors, which have been labeled as self-stimulatory. The most prominent of these

include rubbing her fingers to the point of rawness and repeating her words in a singsong manner.

ICAP scores and other informal data indicate self-abuse is no longer a component of Tammy's behavior. Her trash picking and minor incidents have decreased by forty-eight percent since moving in with a host family and her skill levels or adaptive scores have increased by five percent. During Tammy's last five years at the group home, she had a PRN (as needed) medication to help reduce anxiety and self-abuse. This medication was administered one to two times per month. Since her move to a host family Tammy has not required any of this type of medication. She has been able to decrease or discontinue two psychotropic medications.

The most positive aspect of Tammy's current life is the overall sense of belonging she has with her new family. She is very verbal about expressing her feelings about not wanting to move back into a group home. Although T.W. has been with her host family less than one year, the family states they would not know what to do if Tammy ever had to move, she is definitely a part of the family.

Frances, Case Study #2

Frances is a thirty-eight year old woman of Hispanic decent. Her primary diagnoses include Post-traumatic Stress Disorder (Chronic), Personality Change due to Left Hemispherectomy Combined Type (DSM-IV, 309.81 and 310.10), Borderline Personality Disorder and Mild Mental Retardation (DSM-IV, 301.83

and 317.00). Her secondary disabilities are Seizure Disorder, Morbid Obesity, and Left Hemispherectomy (Bowling, 1996).

Frances was born in February of 1962, in Southeast Wyoming. At the age of two and a half, she began to have seizures after contracting encephalitis. She attended public school from 1968 to 1977. In 1974, Frances was placed in a foster home because of reported physical and sexual abuse from her father (case notes, WSTS, 1978). After living in foster home placement for three years, Frances became extremely aggressive, violent and destructive. At this time, December of 1977, Frances was admitted to the Wyoming State Hospital in Evanston, Wyoming for a psychological and behavioral evaluation.

In January of 1978, she was admitted to the Wyoming State Training School in Lander, Wyoming. At the State Training School, she received educational programming at Emerson School until her adulthood. Frances received behavior programming throughout her stay at the State Training School. She continued to exhibit aggressive and destructive behaviors and experienced several seizures per month (Social Summary, 1989).

Frances transitioned to Big Horn Enterprises in Thermopolis, Wyoming in November of 1986. Two months after her placement she began to exhibit aggressive behaviors. The behaviors included scratching and biting staff, breaking eyeglasses, and verbally threatening to kill staff. While in the Thermopolis program Frances lived in two different group homes, trained as a housekeeper at the Holiday Inn, worked in a sheltered workshop doing assembly type projects and attended day habilitation.

During the summer of 1992, Frances physically injured another resident at Big Horn Enterprises. She was admitted to Crestview in Casper, Wyoming for psychological and behavioral evaluations. After the evaluation, Frances did not return to Thermopolis, but moved to Big Horn Enterprises' program in Powell, Wyoming. She continued to exhibit the maladaptive behaviors of aggression and violence toward staff and the destruction of property. In August of 1996, Frances was admitted to Mountain Regional Services, Inc., for another psychological and behavioral evaluation. Her medications were changed and a behavior plan was developed by this organization. After her return to the Powell group home, Frances received one on one staffing and the prescribed behavior plan was followed. Aggressive behaviors continued with an average of 9.25 incidents occurring per month (Incident Reports, 1996-1999).

In May of 1999, Frances was admitted once again to Mountain Regional Services, Inc., for evaluation. After her release however, a dramatic change took place in Frances' life – she moved in with a host family in Thermopolis. She also began receiving one on one staffing for a community based day habilitation program. Frances' new family, a married couple, also has another individual with developmental disabilities living with them. Frances has her own bedroom with room for her television, VCR, and all her personal belongings. She has had the opportunity to recently visit with her biological family in Laramie, Wyoming.

Frances has a history of engaging in aggressive and violent behaviors toward others and has a history of frequent seizure activity since the age of two and one half years of age. Her aggression has taken the form of scratching, biting, hitting,

kicking and using an object to hit some one with. Her seizure activity could be as high as 24 notable seizures per month (Seizure Reports, 1996-1999). Frances had received extensive medication changes with little results.

Since moving in with a host family, Frances' ICAP scores have shown improvement in maladaptive, adaptive and the overall service score. Her maladaptive score decreased by seventy-four percent and her adaptive level increased by five percent. Incident reports of maladaptive behavior decreased by ninety-eight percent and the amount of seizure activity has been reduced by ninety-six percent. Frances' antidepressant medication has been decreased by 75 milligrams per day and has been able to discontinue the use on one psychotropic medication. During 1998, Frances was prescribed Ativan, both oral and injection form, for aggressive behavior. From May of 1998, to May of 1999, Frances was administered an average of 24 tablets and three injections per month. Since her move to the host family she has had one injection and seven doses of Ativan during her first month. She has not received a single dose of this type of medication since then (Nursing Notes, 1998-2000).

For the first time in her life, Frances has control over her behaviors and her seizures. She has a bubbly personality, likes to tease and be teased and has comfortably acclimated to her new home. The host family emits a genuine concern and love for Frances that she has, for so many years longed to have. Her new family has opened their home and their hearts to provide an understanding and safe environment for Frances.

Bill, Case Study #3

Bill is a 59 year old male of average size and build. He wears glasses and hearing aids. His primary disabilities are severe mental retardation (DSM-IV, 318.10) with his secondary diagnosis as Frotteruism (302.89) disorder (sexual urges or behaviors involving touching and rubbing against a non-consenting person).

Bill was born on June 6, 1940 in a small farming community in the southwestern part of Iowa. His family became aware of his developmental delays when he was two years of age. A sister relayed that the family suspected sexual abuse by a male babysitter. He was acting out sexually and preoccupied with sexuality (Collins-Jones, 1999). At the age of 18, Bill was admitted to the Wyoming State Training School in Lander, WY because as his sister states she knew something was wrong with Billy (Faulkner, 1996).

During Bill's first admission of 22 years to WSTS, he received residential and vocational training. Bill was employed in the laundry room where he operated a folding machine. He also received training in making a sandwich, cleaning his room, brushing his teeth and pedestrian safety. Bill received behavior programming throughout his stay to address his screaming (seeing ghosts), excessive masturbating, inappropriate touching of females and males and taking his clothes off in public.

In 1980, Bill was discharged to Southwest Wyoming Rehabilitation Center, a community based program in Rock Springs, Wyoming. Bill was once again admitted back to WSTS in 1983 because he was leaving the group home in

various stages of undress, going into neighbors' homes and uncontrolled screaming. Bill continued to receive behavior training to address these maladaptive behaviors until his discharge to Big Horn Enterprises in Thermopolis, Wyoming in 1991.

Bill lived in a Thermopolis group home until 1992 when he was moved to Big Horn Enterprises program in Powell, Wyoming. Bill has lived in several Powell group homes where he has continued to receive behavior programming for screaming, stomping, staring at females' chests, touching females inappropriately and gesturing towards his genitals and making noises. In 1996, Bill was referred to Mountain Regional Services, Inc., for a psychological and psychiatric evaluation as a result of his continued maladaptive behaviors. His medications were changed and a behavior plan was developed. After his return to the Powell program, Bill received 1:1 male staffing during day programming and in the group home and the prescribed behavior plan was followed. Maladaptive behaviors continued in spite of the new medications and 1:1 staffing. Bill participated in a day program, where he received training in appropriate communication and socialization. Bill's community and leisure activities included bowling, going for walks, visiting the police station, playing cards, and eating out.

In August of 1999, Bill moved into a host family setting. His new family consists of a married couple with a 15-year-old son. Bill has his own bedroom for all his personal belongings. He still attends day programming and earns money by assembling key chains and cleaning the office building. Bill has had the opportunity to experience many things, since moving in with his host family. He

has gone to Disneyland, Idaho and shopping in Billings, Montana. He has been hunting and fishing with his host family provider. Goes out to eat and to movies. Bill requires redirection, structure, and limit setting to prevent him from exhibiting the sexually maladaptive behaviors. Bill's host family is able to provide this on a consistent basis. Bill continues to attend Day Programming with Big Horn Enterprises.

ICAP scores and other informal data methods indicate that Bill has seen improvement since moving in with a host family. His maladaptive behavior (screaming, stomping, and sexually acting out) has decreased by eighteen percent and his adaptive scores have increased by five percent. The number of incident reports on Bill's maladaptive behavior has decreased by eleven percent. During his last two years at the group home, Bill received an average of thirteen Ativan tablets per month to reduce anxiety. After his move to the host family, he continued to need the same medication the first three months of placement but in the last three-month period he has only required a total of two tablets (Nursing Notes, 1998-2000). Medications are currently being re-evaluated to decrease his sexual behaviors by a psychiatrist at Mountain Regional Services Incorporated.

Bill's new family provides a sense of security and structure in his life. He has experienced various outdoor activities that he could not do while in a group home. Bill is adjusting well in this new environment and plans to be an active member of the family for as long as possible.

Bonnie, Case Study #4

Bonnie is a forty-six year old woman with various diagnoses to include: Moderate Mental Retardation (DSM-IV 318.0), Down Syndrome, Obsessive Compulsive disorder (DSM-IV 300.3), mitral valve prolapse, Congenital Heart Failure and Hyperthyroidism (Collin-Jones, 1999). Bonnie is able to sign 'yes' and has created several signs of her own to communicate to others. She has numerous scars on her hands from scratching and biting herself when she has been frustrated. Bonnie's upper and lower incisors were removed at some point in her past to keep her from biting herself (Kuchel, 1999).

Bonnie was born in Greybull, Wyoming, a small farming community in Northern Wyoming. She was admitted to the Wyoming State Training School in December of 1957, due to her limited self-care skills, delayed language development, and her mother's inability to manage her behaviors (Collins-Jones 1999). During her thirty-two year placement at the Training School, Bonnie exhibited self-injurious behavior and physical aggression toward others. She did not like to associate with other residents and chose to isolate herself (Case notes, 1989). Her daily activities included swimming, van rides, listening to music and dancing. She enjoyed work activities where she could remain seated.

In November of 1990, Bonnie moved to the Fremont group home at Big Horn Enterprises in Thermopolis. During her placement in Thermopolis, she lived in the group home with other residents (two to three) and reportedly had several obstreperous outbursts. These outbursts also included self-injurious behavior (scratching, biting and hitting her head on the floor) and elopement. Bonnie

continued to have many of the same interests as she did at the Training School – van rides, listening to music and dancing.

In November of 1990, Bonnie moved to Big Horn Enterprises' program in Powell. This move placed Bonnie closer to part of her family, two sisters who live in different parts of Montana, one of which is her guardian. Bonnie enjoys family visits and outings. From 1990 to 1999 she lived in various group homes and attended Day Habilitation. She prefers to be in small, structured settings due to feeling overwhelmed by large groups of people and/or crowds. She continues to engage in some self-injurious behavior when she is not allowed to do something that she wants to do. She enjoys organizing things and putting puzzles together.

Bonnie moved into a host family in August of 1999. She enjoys helping with household tasks, watching movies, and listening to music. Bonnie delights in talking to and spending time with her host family provider. She continues to attend Big Horn Enterprises' Day Habilitation program five days a week. In Day Habilitation Bonnie participates in outdoor excursions, organize things, and listen to music.

The transition to a host family has had many positive behavioral changes reported, most importantly there has been a reduction in compulsive and self-injurious behaviors (Kuchel, 1999). ICAP scores indicate a fifty percent decrease in maladaptive behaviors and a four percent increase in adaptive behaviors. The number of recorded incident reports has decreased by eighty-four percent since her move into a host family. In a fifteen-month period prior to Bonnie's move,

she received 37 tablets per month of an anti-anxiety medication. By March of 2000, all medications were discontinued (Nursing notes, 1998-2000).

Before moving to a host family, Bonnie would not sleep under the covers no matter the temperature of the room. She is now staying under the covers throughout the night. She is no longer afraid of dogs or other animals and spends part of her leisure time out of doors feeding and petting them. One notable observation about Bonnie is her artwork. She continues to enjoy water colors and finger painting, but the colors she uses have changed from black or very dark colors to yellow and several lighter colors. Another major change in Bonnie is she no longer elopes from her place of residence. This is a significant change from the group home, where she was supervised closely during waking hours. In the past Bonnie has been virtually non-verbal, but has recently begun to verbalize her wants and needs. She can call people by their names, pronounce dog, pop, and other simple locutions.

In the upcoming months, Bonnie has some exciting vacation plans. Her and her host family plan to travel to Idaho and meet the host family's family. Bonnie is looking forward to her vacation and can not wait for a few days of rest and relaxation.

Discussion

Clear improvements in maladaptive and adaptive behaviors have been documented in host family settings. Also noted were the decreases in psychotropic medications. The future will involve continuing advances in the opening of family homes in all parts of rural Wyoming to mainstream activities on

the part of people with developmental disabilities, given commitment to basic beliefs and effective services from professionals and other service providers. One such home has recently opened in Southeastern Wyoming in Torrington. Future research should be continued concerning the improvement of individuals with developmental disabilities in a host family setting. Research also should be developed to evaluate the efficiency and effectiveness on the part of service providers. This research could include cost effectiveness, the effect of staff turnover in group home settings compared to living in a long term placement with a host family, and effectiveness of incidental training.

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